

STATEMENT ON MEDICARE 'REFORM'

by

Bruce C. Vladeck, Ph.D.

Before the Hearing on

"Health Care Entitlements: The Road Forward"

Committee on Finance

United States Senate

June 23, 2011

Mr. Chairman, Senator Hatch, Members of the Committee, it is a great pleasure and honor to have the opportunity to appear before you today. I am Bruce C. Vladeck, Senior Advisor to Nexera, a consulting subsidiary of The Greater New York Hospital Association. I am also Chairman of the Board of the Medicare Rights Center, and a Trustee of Ascension Health. The views I express today are solely my own and not necessarily those of any of those organizations.

Mr. Chairman, it has been 14 or 15 years since I last sat at this table, in a rather different role, and while much has obviously changed since then, I confess to a very strong sense of déjà vu this morning. In 1996 and 1997 – and then through 1999, when I served as a member of the National Bipartisan Commission on the Future of Medicare – there was a putative “crisis” in Medicare that was considered central to any plan to reduce a serious federal budget deficit. The Hospital Insurance Trust Fund faced looming insolvency, and the projected growth rate of Medicare expenditures was forecast to crowd out other discretionary expenditures and make deficit reduction unattainable. The growth in Medicare expenditures was widely characterized as “unsustainable.”

The Congress took action in 1997, as it had many times before in the history of the Social Security Act, and by 1999 the federal budget was in surplus. The expected life of the Hospital Insurance Trust Fund was extended by twelve years, and in calendar year 1998 total Medicare outlays actually went down compared to the prior year. The Balanced Budget Act (BBA) kept Medicare on a sound financial footing for another 10 to 15 years. There’s no reason we can’t do that again, just as we did in 1972, 1982 and 1983. In short, while the Medicare program has long-term financial problems that must be addressed, as I will discuss, the current so-called “crisis” is in fact an artifact of broader problems with the federal budget and budgetary politics, and should not be used as an excuse to dismantle one of the most important programs the federal government has ever operated, or to renege on the commitment this government has made to generations of working people as it has collected taxes from them.

In that context, I’ve organized the balance of my remarks today into three sections. First, I will speak very briefly about the relationship between Medicare’s finances and broader economic trends. Second, I will take note of some recent developments in Medicare’s evolution and show how they connect to alternative approaches to Medicare’s finances. All roads lead, I believe, to the much more fundamental problem of health care costs and how their growth can be decelerated, and discussion of that subject will conclude my written remarks.

The Two Sides of Medicare Solvency

The Congressional Budget Office (CBO) originally estimated that the BBA would extend the life of the Hospital Insurance Trust Fund by 10 years, to 2008, but by 2001 the estimated exhaustion date for the Fund had been moved outward another 21 years, to 2029. No significant Medicare

policy changes were enacted during that period, although the CBO had corrected its wildly inaccurate projections of the BBA's budgetary effects. Instead, what changed was that the economy grew much more rapidly than CBO or the Office of Management and Budget or anyone else had expected. More recently, the 2011 Report of the Medicare Trustees reduced the Trust Fund's expected years of remaining solvency, again not because of any policy changes or any radical surprises in Medicare's rate of expenditures, but because the nation's economy has emerged much more slowly than expected from the effects of the recession that began in 2008. All of that is a useful reminder that the actuarial balance of Medicare (whether in the Trust Funds or through general revenue) is affected by two phenomena. We tend to focus most of our attention on the program's outlays, but the other half of the equation is income. And income is determined by the level of economic growth and by tax rates.

The most important thing that can be done to improve Medicare's long-term fiscal outlook (and, for that matter, Social Security's), is to get the economy growing again. I know how obvious that sounds, but since we health policy wonks often seem oblivious to what's going on in the rest of the economy, I believe it's an essential reminder. It's worth repeating that the percentage of gross domestic product (GDP) accounted for by Medicare, or more relevantly by all health care expenditures, depends just as much on how big GDP is as on how much health care costs. At the same time, as the number of Medicare beneficiaries roughly doubles over the next 25 years, unless we are far more successful at reining in cost growth than anyone has predicted might seem possible, we are going to have to add some money to the program, either from general revenues or, I would prefer, a more progressive revenue source.

Approaches to "Reform"

The relationship between outlays and revenues hasn't changed since 1997, but much else has:

- Out-of-pocket costs for Medicare beneficiaries, largely in the form of soaring premiums, have skyrocketed, while incomes of seniors (like those of most Americans except the wealthiest) have stagnated;
- At the same time, the proportion of working people with employer-provided retirement health benefits that supplement basic Medicare coverage has plummeted, and is likely to effectively disappear altogether in the foreseeable future, meaning that future generations of Medicare beneficiaries will have even less protection against out-of-pocket costs than current beneficiaries.
- A prescription drug benefit was added to the Medicare program. While Part D is more expensive and cumbersome, and imposes greater burdens on beneficiaries than might have been necessary, it has unquestionably brought significant help to millions of Americans. But it was enacted without any specific financing

mechanism other than the shares accounted for by beneficiary premiums and State contributions, and has contributed materially to the expected long-term growth in Medicare's general revenue expenditures.

- As has always been anticipated, the number of Medicare beneficiaries has continued to grow at a pace that will accelerate as we “baby boomers” increasingly reach retirement age;
- Overall health care costs have continued to grow substantially faster than the rest of the economy;
- Because private sector costs have grown more substantially than Medicare's costs each of the last 15 years, the difference in payment rates between Medicare and private insurers for hospital and physician services has widened considerably. As Medicare patients comprise an ever larger share of all hospital patients, this puts increasing financial pressure on hospitals in rural areas and less-affluent urban communities;
- and, of course, The Affordable Care Act (ACA) was enacted in 2010, which not only significantly strengthened Medicare's finances, but also laid out a number of mechanisms designed to encourage greater effectiveness and efficiency in the health care system.

In other words, despite all these significant developments, what was true about Medicare during the deliberations of the National Bipartisan Commission remains just as true today:

- Even with the addition of the prescription drug benefit and expanded coverage for certain preventive services, the Medicare benefit package remains woefully inadequate. On average, Medicare pays less than half the health care costs of its beneficiaries. In the terminology of the ACA, this would not even qualify as “Bronze” coverage, even though Medicare beneficiaries have the highest burden of illness of any demographic group in the insurance market.
- Partially as a result of the benefit structure, as a share of their incomes Medicare beneficiaries pay three times as much out-of-pocket as the privately insured, although their income is, on average, only half as great.
- There remain significant opportunities for savings in the Medicare program – in the prices Medicare pays, for example, for durable medical equipment, clinical laboratory services, and prescription drugs – that the Congress continues to ignore or reject.

In other words, the traditional knee-jerk approaches to reducing health insurance expenditures are especially inappropriate for Medicare. Not only shouldn't we reduce benefits from their already minimal levels; when budgetary circumstances are more favorable we should significantly *improve* them. Out-of-pocket costs for Medicare beneficiaries already exceed any conceivable threshold at which behavior might have been altered, and a growing body of data makes clear that increased out-of-pocket expenditures at the point of service are as likely to deter clinically

necessary utilization, with serious health consequences, as less necessary utilization. We could continue to raise the costs of Medicare for upper-income beneficiaries, but we've done that twice already, in 1997 and 2010, without major effects on Medicare's overall financial health. We could increase the age of eligibility for Medicare as the ACA takes effect, but doing so would achieve savings for the government largely by shifting the costs to beneficiaries and employers. And if we increase the eligibility age and repeal the ACA in total or in part, millions of especially vulnerable citizens will be left uninsured and uninsurable.

There's really only one way out: In order to keep the promise of Medicare – affordable access to mainstream medical care for older and disabled Americans - without any further hollowing-out of what that promise contains, we have to achieve substantial reductions in the rate of growth of health care costs. Of course, we also have to achieve substantial reductions in the rate of growth of health care costs in order to move towards coverage for all Americans, avoid ruin for American businesses large and small, and avoid a more general economic catastrophe.

Addressing Health Care Costs

In talking about health care costs, it's first essential to distinguish between approaches that actually get to the costs of producing and obtaining health care from those that merely limit the federal government's costs by shifting them on to sick people. Proposals such as that adopted by the House Budget Committee, for example, effectively cap the government's liabilities, but they do so primarily by shifting costs to beneficiaries who, despite a lifetime of payroll tax contributions, are already paying more for their health care than other Americans. More sophisticated proposals like "premium support" are fundamentally the same wolves dressed up in fancier clothing. We have 25 years of empirical experience that consistently confirms the point that private plans simply cannot deliver a defined package of health insurance benefits less expensively than Medicare does. In terms of dollars spent for services actually provided, the only health insurance program in the United States less expensive than Medicare is Medicaid. Creating a voucher with which to purchase private plans while saving the federal government money will therefore inevitably increase costs to beneficiaries, or reduce the value of the benefits they receive, or – most likely – both.

The alternative approach to controlling the growth in health care costs is more difficult, more complex, and more frustrating – as well as more likely to gore the oxen of particular private interests. It's no wonder that pundits and politicians shy away from them. But there really isn't a defensible alternative. We need to get to work.

We need to encourage changes in our delivery system that increase efficiency, reduce waste, increase patient satisfaction, and improve outcomes. We also need to find better ways to pay for health services – whether the payer is public or private. None of this is easy to do. But the

Congress, and especially this Committee in its work on the ACA, laid out a multi-pronged effort to systematically test and evaluate almost every approach anyone could think of – and, through the Center for Medicare and Medicaid Innovations (CMMI), some that haven't yet been even thought of. In many instances, these provisions of the ACA focus on efforts not confined to Medicare itself, but capable of engaging and encouraging parallel efforts by private insurers, to achieve a wider impact on health care costs. Personally, I'm skeptical about a number of the approaches promoted by the ACA, but we don't have to bat 1.000, or anywhere close, to identify things that will really work.

For example, demonstration projects that share cost savings between hospitals and physicians at Beth Israel Hospital in New York and twelve hospitals in New Jersey are already producing significant cost reductions and improved quality of care. Medicaid Health Homes demonstrations, by testing better ways of managing care for individuals with complex chronic illnesses, may well point the way for similar arrangements for Medicare patients. And for the first time since the adoption of the PACE benefit in the BBA, we are seeing widespread planned experimentation in delivery models for chronically ill dually-eligible Medicare/Medicaid beneficiaries. This is hardly a complete list, and this entire effort is a work in progress – now just at its earliest stages. But it's the most systematic effort of its sort in the history of American health care.

And if all these efforts to encourage appropriate changes in health care delivery and health care payment mechanisms fail to stanch the flow of health care inflation, the inevitable fallback is reductions in payment rates to providers. I personally have some serious reservations, on both administrative and policy grounds, about the Independent Payment Advisory Board (IPAB), but the BBA and literally dozens of other federal and state policy changes over many years make several things clear:

- You can save money, both in the short term and permanently, by reducing payment rates to providers and plans;
- Under the appropriate circumstances, carefully-designed payment reductions can reduce outlays without affecting access to care or negatively affecting quality. Indeed, sometimes they can lead to significantly increased quality. But the risks are real, so the process requires careful deliberation, sophisticated analysis, and open, participative decision-making. How to achieve such a process is, of course, the very issue with which you are now grappling relative to the future of IPAB.
- The organizations whose payment rates are reduced are going to be very mad at their elected representatives.

In other words, as a last resort in the event that delivery system reform doesn't save enough money, preserving the Medicare benefit will require payment rate reductions. That should be a major incentive for the provider community to achieve savings before we get to that point, and

for elected officials to energetically encourage them. But if reform fails to meet its savings targets, someone is going to have to take the heat for payment reductions.

In deference to the Committee's constraints, this has obviously been a very condensed review of a number of important topics. I'd be delighted to respond to any questions anyone might have.

Once again, I am honored by the opportunity to appear before you today, and I thank you very much for the privilege and for your attention.